Reviewed and approved 4/15/14 Linda Brown RD
Notified NHA 4/15/14 @ 0950. LB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536025	A. BUILDING _____ B. WING _____	C 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADON - Assistant Director of Nursing DON - Director of Nursing MAR - Medication Administration Record MDS - Minimum Data Set PRN - Pro re nata (as needed) Mg - Milligrams Mcg - Micrograms Less common abbreviations will be annotated in each deficiency.	F 000	**Preparation and/or execution of the response and plan of correction do not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.**	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	F-272 COMPREHENSIVE ASSESSMENTS **Corrective Action** Residents #38, #39, #41, #49, #52, #54, #55, #75, #77, and #100's comprehensive assessments will be reviewed by the IDT to determine if a significant change of status assessment needs to be completed to re-establish plan of care with further CAA analysis. If appropriate care planning is in place and assessment is accurate then the CAA's will be redone with further analysis at the time of the next due comprehensive assessment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Senior Administrator 4-13-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APR 13 2014

Healthcare Licensing and Surveys

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F 272	Continued From page 1 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure care area assessments (CAAs) were comprehensive in a variety of triggered areas for 10 of 17 open sample residents (#38, #39, #41, #49, #52, #54, #55, #75, #77, #100). The findings were: 1. Review of the 1/3/14 admission MDS assessment showed resident #77 triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive Loss/Dementia, Communication, ADL Function/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of	F 272	**Identification of Others** Comprehensive assessments of current residents completed within the last 60 days will be reviewed by the IDT to determine if a significant change of status assessment is needed to re-establish an appropriate plan of care through further CAA analysis. Any resident identified as needing a further analysis of findings will have a significant change of condition scheduled and completed within 14 days of the ARD. **Systemic Changes** The Resident Care Management Director and the MDS Coordinator will be provided education by the Division Director of Care Management or designee regarding CAA completion and analysis of findings on or before the date of compliance. The Resident Care Management Director and MDS Coordinator will attend a RAI training to include CAA's and care planning on 4/9/14 and 4/10/14. Comprehensive assessments scheduled and completed after the date of compliance will have comprehensive CAA analysis and thorough review. The Division Director of Care Management or designee will randomly audit 25% of comprehensive assessments completed weekly for thorough completion of CAA's and analysis of findings for 90 days.	

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F 272	Continued From page 2 an assessment of the data. 2. Review of the 10/2/13 significant change MDS assessment showed resident #64 triggered for multiple areas which required additional comprehensive assessment. These areas included: ADL Function/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 3. Review of the 9/13/13 annual MDS assessment showed resident #49 triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence, Behavioral Symptoms, Activities, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 4. Review of the 3/7/14 annual MDS assessment showed resident #52 triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive Loss/Dementia, Communication, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use and Pain. Review of the	F 272	**Monitoring** The Resident Care Management Director /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	

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F 272	Continued From page 3 corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 5. Review of the 9/13/13 significant change MDS assessment showed resident #55 triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive Loss/Dementia, Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 6. Review of the 1/21/14 admission change MDS assessment showed resident #75 triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use and Pain. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data.	F 272		

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F 272	Continued From page 4 7. Review of the 12/14/13 annual MDS assessment showed Cognitive Impairment triggered for comprehensive assessment for resident #39. Review of the corresponding CAA for this area showed the assessment/analysis of the triggered area was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 8. Review of the 9/30/13 annual MDS assessment showed the following areas triggered for comprehensive assessment for resident #38: Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 9. Review of the 6/25/13 initial MDS assessment showed the following areas triggered for comprehensive assessment for resident #100: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Nutritional Status, Pressure Ulcer, Physical Restraints, and Pain. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 10. Review of the 6/23/13 annual MDS assessment showed the following areas triggered	F 272		

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F 272	Continued From page 5 for comprehensive assessment for resident #41: Cognitive Loss/Dementia, Communication, Urinary Incontinence, Falls, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. Review showed only data from the MDS assessment was re-written on the CAA instead of an assessment of the data. 11. Interview with the MDS coordinator on 3/20/14 at 3:20 PM verified staff "got behind" on completion of the MDS assessments and CAAs were not always done comprehensively.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F-279 DEVELOP COMPREHENSIVE CARE PLANS **Corrective Action** Resident #75 is no longer a resident of the facility. **Identification of Others** The Resident Care Management Director and/or Designee will conduct a facility-wide audit of current incontinent residents for presence of an incontinence care plan. An incontinence care plan will be developed as needed based on audit results.	

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 21 sample residents (#75). The findings were: Review of the medical record revealed resident #75 was admitted to the facility on 1/7/14 with diagnoses that included Huntington's disease. The admission MDS assessment dated 1/20/14 revealed the resident was occasionally incontinent, on a toileting program, and required the extensive assistance of one person for toileting. Review of section V of the MDS assessment showed, based on further assessment of urinary incontinence, a decision was made to address incontinence with a care plan. However, no care plan for toileting or incontinence was located in the resident's record. Interview with the MDS coordinator on 3/20/14 at 3:50 PM confirmed no care plan for incontinence was developed for this resident.	F 279	**Systemic Changes** The Division Director of Care Management or designee will provide education to the Resident Care Management Director, MDS Coordinator, and the IDT addressing comprehensive care plan development, including development of incontinence care plans as needed. The Resident Care Management Director/Designee will conduct random weekly audits for four (4) weeks and monthly audits for three (3) months for residents on care conference schedule to confirm the existence of appropriate incontinence related care plans for affected residents. **Monitoring** The Resident Care Management Director / Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders regarding treatments for 1 of 21 sample residents (#100). The findings were:	F 281	F-281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS **Corrective Action** Resident #100 has discharged from the facility.	

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F 281	Continued From page 7 Review of the 2/14/14 physician's orders for resident #100 showed an order to wrap the lower extremities every day from the toes to knees with ace wraps. Further orders showed the wraps should be on in the morning and off at bedtime. In addition, the resident's skin integrity was to be assessed and documented before placing and after removing the wraps. Review of the February 2014 and March 2014 treatment administration records (TARs) showed no evidence the wraps were removed at bedtime and the skin integrity was assessed on 2/26/14, 2/26/14, 3/2/14, and 3/3/14. Further review showed no evidence the wraps were utilized as ordered on 2/27/14. In addition, review of the February 2014 and March 2014 recapitulation of physician orders showed an order dated 8/15/13 to titrate the resident's oxygen in an attempt to reduce oxygen use while maintaining the oxygen saturation rate above 89%. Review of the February 2014 and March 2014 TARs showed no evidence the saturation rate was obtained on the evening shifts on 2/3/14, 2/5/14, and 2/6/14. Also, there was no evidence the saturation rate was assessed during the night shift on 2/10/14, 2/12/14 and 3/12/14. Interview with the DON and ADON on 3/20/14 at 1 PM revealed physician orders should always be followed as written and they were unsure why the above noted omissions occurred. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, nursing must function under the direction of a licensed physician.	F 281	**Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit to confirm physician orders for current residents with ace wraps and oxygen saturations are followed and properly documented for the past 2 weeks. Corrective actions will be taken for identified concerns. **Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses addressing the following of physician orders and documentation on treatment records, including documentation of ace wraps and oxygen saturations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

4/5/14

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F 281	Continued From page 7 Review of the 2/14/14 physician's orders for resident #100 showed an order to wrap the lower extremities every day from the toes to knees with ace wraps. Further orders showed the wraps should be on in the morning and off at bedtime. In addition, the resident's skin integrity was to be assessed and documented before placing and after removing the wraps. Review of the February 2014 and March 2014 treatment administration records (TARs) showed no evidence the wraps were removed at bedtime and the skin integrity was assessed on 2/25/14, 2/26/14, 3/2/14, and 3/3/14. Further review showed no evidence the wraps were utilized as ordered on 2/27/14. In addition, review of the February 2014 and March 2014 recapitulation of physician orders showed an order dated 8/15/13 to titrate the resident's oxygen in an attempt to reduce oxygen use while maintaining the oxygen saturation rate above 89%. Review of the February 2014 and March 2014 TARs showed no evidence the saturation rate was obtained on the evening shifts on 2/3/14, 2/5/14, and 2/6/14. Also, there was no evidence the saturation rate was assessed during the night shift on 2/10/14, 2/12/14 and 3/12/14. Interview with the DON and ADON on 3/20/14 at 1 PM revealed physician orders should always be followed as written and they were unsure why the above noted omissions occurred. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, nursing must function under the direction of a licensed physician.	F 281	The Director of Nursing/Designee will conduct random weekly audits for four (4) weeks and monthly audits for three (3) months to confirm physician orders for ace wraps and oxygen saturations are followed and documented on treatment records. **Monitoring** The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F-282 SERVICES BY QUALIFIED PERSONS PER CARE PLAN	

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F 282	Continued From page 8 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan for 2 of 21 sample residents (#41, #97). The findings were: 1. Review of the admission care plan showed resident #97 experienced actual pain due to a recent fall. Review of the 12/31/13 care plan interventions showed staff should observe the resident for signs and symptoms of pain, including verbal expressions and non-verbal expressions every shift. However, review of the PRN pain MAR showed the resident's pain level was not assessed on the evening and night shifts on 1/3/14, 1/7/14, 1/8/14 and 1/9/14. Review also revealed the resident's pain level was not assessed during the night shift on 1/1/14, 1/4/14, 1/6/14, 1/10/14, 1/11/14, 1/12/14 and 1/13/14. Interview with the DON and ADON on 3/20/14 at 1 PM verified the resident's care plan should have been followed, especially for pain since the resident was admitted because of a fall at home which resulted in pain. 2. Review of the March 2014 physician orders showed resident #41 had an indwelling urinary catheter. Observation on 3/17/14 at 2:20 PM showed the resident was transferred from the wheelchair to the bed using a mechanical lift. Observation showed during the transfer the	F 282	**Corrective Action** Resident #97 has discharged from the facility. The SDC will educate primary resident care specialist care givers of resident #41 on having her catheter bag and tubing placed below her bladder during transfers involving a mechanical lift. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of pain MAR's and documentation of pain per pain scale on medication administration record for current residents for past 2 weeks to confirm resident's pain levels are assessed in accordance with the resident's care plan. Corrective action will be taken as needed for identified concerns. The Director of Nursing/Designee will conduct a facility-wide observation audit to confirm current residents with indwelling catheters requiring the use of a mechanical lift have their catheter bags located below the bladder during the transfer and in accordance with the care plan. Corrective actions will be taken as needed for identified concerns.	

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F 282	Continued From page 8 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan for 2 of 21 sample residents (#41, #97). The findings were: 1. Review of the admission care plan showed resident #97 experienced actual pain due to a recent fall. Review of the 12/31/13 care plan interventions showed staff should observe the resident for signs and symptoms of pain, including verbal expressions and non-verbal expressions every shift. However, review of the PRN pain MAR showed the resident's pain level was not assessed on the evening and night shifts on 1/3/14, 1/7/14, 1/8/14 and 1/9/14. Review also revealed the resident's pain level was not assessed during the night shift on 1/1/14, 1/4/14, 1/6/14, 1/10/14, 1/11/14, 1/12/14 and 1/13/14. Interview with the DON and ADON on 3/20/14 at 1 PM verified the resident's care plan should have been followed, especially for pain since the resident was admitted because of a fall at home which resulted in pain. 2. Review of the March 2014 physician orders showed resident #41 had an indwelling urinary catheter. Observation on 3/17/14 at 2:20 PM showed the resident was transferred from the wheelchair to the bed using a mechanical lift. Observation showed during the transfer the	F 282	**Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses on following the plan of care including addressing the facility's pain management system, including documentation of pain assessment on pain MAR and medication administration record. The Staff Development Coordinator/Designee will provide education to licensed nurses and certified nurse aides on following the plan of care including addressing the appropriate mechanical lift transfer protocol for residents having indwelling catheters. The Director of Nursing/Designee will conduct random weekly audits of medication administration records for four (4) weeks and monthly for three (3) months to confirm resident's pain is assessed and documented in accordance with the care plan. Random observation audits of transfers with mechanical lift of 4 residents with indwelling catheters will be conducted by Director of Nursing or designee to monitor for proper positioning of catheter during the transfer. The audits will be conducted weekly for 4 weeks and then monthly for 3 months.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 9 Indwelling catheter bag and tubing was placed above the resident's bladder allowing urine to flow back into the bladder. Review of the 7/19/13 care plan showed instructions to "Secure catheter to facilitate flow of urine maintaining urinary drainage bag below level of bladder." Interview with the DON and ADON on 3/20/14 at 1 PM verified placing the catheter bag above the bladder during the transfer was not acceptable practice. They further stated resident care plans should be followed.	F 282	**Monitoring** The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the pain management policy, the facility failed to ensure the necessary assessments and monitoring was implemented to ensure adequate pain management for 1 of 8 sample residents (#41) who had pain. In addition, the facility failed to ensure an adequate assessment of a change in condition was performed for 1 of 1 sample resident (#97) who had a change in condition. The findings were: 1. Review of the medical record showed resident #41 had diagnoses including brain injury and was	F 309	F-309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING **Corrective Action** The Director of Nursing or designee will review documentation of pain for the past 2 weeks for resident #41. Additionally, resident #41's pain assessment will be reviewed and updated as needed. The attending physician will be contacted as needed to review findings and pain medication regimen. Resident #97 has discharged from the facility.	

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F 309	Continued From page 10 unable to speak. Review of the 1/30/14 quarterly MDS assessment showed, based on non-verbal sounds and facial expressions, the resident experienced pain one to two days per week and received both routine and PRN pain medications. Review of the March 2014 physician's orders showed there was an order for oxycodone-acetaminophen (narcotic) 5 mg/325 mg every 6 hours as needed for pain. Review of the orders showed there was also an order for ibuprofen 600 mg every 6 hours as needed for pain. In addition to the PRN orders the resident routinely received Tylenol 325 mg three times per day for comfort. Review of the March 2014 PRN pain MAR showed the following concerns: a. On 3/1/14 during the evening shift (2 PM to 10 PM) the resident was assessed to have a pain level of 8 on a scale of 0 to 10 with 10 being the worst (8/10). Review revealed no evidence the resident was administered any PRN pain medication or provided non-pharmacological interventions. In addition, there was no evidence the resident's pain was monitored or re-assessed again until the next shift. b. On 3/3/14 during the day shift (6 AM to 2 PM) the resident was assessed to have a pain level of 7/10 without evidence pain medication was administered. There was also no evidence non-pharmacological interventions were attempted and the next time the resident's pain was assessed was sometime during the next shift. c. On 3/17/14 during the night shift (10 PM to 6 AM) the resident was assessed to have a pain level of 5/10. Review of the PRN pain MAR showed no evidence the resident was administered PRN pain medication or that non-pharmacological interventions were attempted.	F 309	**Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of resident's pain levels for the past 2 weeks, including assessment and administration of pain medications as needed in accordance with the physician's orders. Corrective actions will be taken as needed for identified concerns. The Director of Nursing/Designee will conduct a facility-wide audit of residents with a change of condition in the past 30 days for appropriate documentation of condition, documentation of physician notification and appropriate orders were obtained. Corrective actions will be taken for identified concerns.	

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F 309	Continued From page 11 d. Review of the facility pain management policy revised on August 2012, showed the following instructions: "The Licensed Nurse, when administering PRN pain medications, will record the drug administration and the following on the MAR: ...Pharmacological interventions attempted; Non-pharmacological interventions attempted; Follow-up observations post intervention to determine the effectiveness of PRN pain interventions." e. Interview with the DON and ADON on 3/20/14 at 1 PM verified the resident's pain was not managed effectively in the above noted examples. 2. Review of the medical record showed resident #97 had a history of allergies to a variety of medications including Benicar, HCTZ (hydrochorothiazide) and Ramipril (all blood pressure medications). Review of the 1/14/14 nursing notes timed at 3 AM revealed the resident had a rash on the chest with areas of excoriation. According to these notes, the resident attributed the rash to an adverse medication reaction. Review of the nursing notes showed "...displays no other S/S [signs and symptoms] of allergy." Review of the medical record showed the next nursing notes written were part of the interdisciplinary discharge summary by the discharging nurse. Review of these nursing notes showed "Upon final assessment, resident had redness and scratch marks to both R [right] and L [left] arms upper and lower, and to upper abdomen and chest." No time of discharge was noted. The following concerns were identified: a. Review of the 1/14/14 nursing notes timed at 3 AM on the day of discharge showed no evidence the physician was notified of the rash or further assessment was performed to determine	F 309	**Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses addressing the systems of pain management and documentation of resident change of condition and physician notification. The Director of Nursing/Designee will conduct random weekly audits of resident medical records and the medication administration record for four (4) weeks and monthly for three (3) months to confirm resident's pain is assessed and managed in accordance with the care plan and change of resident's condition is appropriately documented, physician is notified and appropriate orders are obtained for change of condition. **Monitoring** The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	

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F 309	Continued From page 12 the cause of the rash, whether or not it was medication related or had another cause, and there was no evidence any interventions were attempted to treat the rash. b. Review of the only other nursing notes written on the day of discharge,which were not timed, showed the rash had extended from the chest to both upper and lower arms and to the upper abdomen. Review of the entire record showed the resident was discharged in this condition without notifying the physician, without determining the cause of the rash, and without any type of treatment. c. Interview with the DON and ADON on 3/20/14 at 1 PM revealed the physician should have been notified and further assessment to determine the cause should have been performed.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review and facility policy and procedure review, the facility failed to ensure appropriate	F 316	F-315 NO CATHETER, PREVENT UTI, RESTORE BLADDER **Corrective Action** The SDC will educate primary resident care specialist care givers of resident #41 on having their catheter bag and tubing placed below their bladder during transfers involving a mechanical lift. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide observation audit to confirm residents who use mechanical lift for transfers with indwelling catheters have their catheter bags located below the bladder during the transfer and in accordance with the care plan. Corrective actions will be taken as needed for identified concerns.	

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F 315	Continued From page 13 measures to prevent urinary tract infections were followed for 1 of 3 sample residents (#41) who had an indwelling urinary catheter. The findings were: Review of the March 2014 physician orders showed resident #41 had an indwelling urinary catheter. Observation on 3/17/14 at 2:20 PM showed the resident was transferred from the wheelchair to the bed using a mechanical lift. Observation showed during the transfer the indwelling catheter bag and tubing was placed above the resident's bladder allowing urine to flow back into the bladder. Review of the facility policy and procedure on Indwelling urinary catheter care and management, revised on 10/4/13, showed "Keep the collection bag below the level of the bladder at all times." Interview with the DON and ADON on 3/20/14 at 1 PM verified placing the catheter bag above the bladder during the transfer was not acceptable practice and was contrary to the facility policy and procedure.	F 315	**Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses and certified nurse aides addressing the appropriate mechanical lift transfer protocol for residents having indwelling catheters. Random observation audits of 4 resident transfer with mechanical lifts with indwelling catheters will be conducted by Director of Nursing or designee to monitor for proper positioning of catheter during the transfer. The audits will be conducted weekly for 4 weeks and then monthly for 3 months.. **Monitoring**	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	

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F 328	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure appropriate respiratory management was provided for 1 of 11 sample residents (#100) with oxygen. The findings were: Review of the February 2014 and March 2014 recapitulation of physician orders showed an order dated 8/15/13 to titrate the resident's oxygen in an attempt to reduce oxygen use while maintaining the oxygen saturation rate above 89%. Review of the February 2014 and March 2014 TARs showed no evidence the saturation rate was obtained on the evening shifts on 2/3/14, 2/5/14, and 2/6/14. Also, there was no evidence the saturation rate was assessed during the night shift on 2/10/14, 2/12/14 and 3/12/14. Interview with the DON and ADON on 3/20/14 at 1 PM revealed physician orders should always be followed as written and they were unsure why the above noted omissions occurred.	F 328	F-328 TREATMENT/ CARE FOR SPECIAL NEEDS **Corrective Action** Resident #100 has discharged from the facility. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents treatment records for past 2 weeks to confirm physician orders for oxygen saturations are followed and documented on treatment record. Corrective actions will be taken for identified concerns. **Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses addressing the following of physician orders and documentation on treatment records, including oxygen saturations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		

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F 328	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure appropriate respiratory management was provided for 1 of 11 sample residents (#100) with oxygen. The findings were: Review of the February 2014 and March 2014 recapitulation of physician orders showed an order dated 8/15/13 to titrate the resident's oxygen in an attempt to reduce oxygen use while maintaining the oxygen saturation rate above 89%. Review of the February 2014 and March 2014 TARs showed no evidence the saturation rate was obtained on the evening shifts on 2/3/14, 2/5/14, and 2/6/14. Also, there was no evidence the saturation rate was assessed during the night shift on 2/10/14, 2/12/14 and 3/12/14. Interview with the DON and ADON on 3/20/14 at 1 PM revealed physician orders should always be followed as written and they were unsure why the above noted omissions occurred.	F 328	The Director of Nursing/Designee will conduct random weekly audits of residents with physician orders for oxygen for four (4) weeks and monthly for three (3) months to confirm physician orders for oxygen saturations are followed and documented on treatment records. **Monitoring** The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		

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F 329	Continued From page 16 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a valid physician's order for medication was obtained prior to medication administration for 1 of 21 sample residents (#52). The findings were: Review of the medical record revealed resident #52 was admitted to the facility on 5/24/11 with diagnoses that included joint pain and muscle disuse atrophy. Review of the resident's MAR for the month of February 2014 revealed the resident received doses of hydrocodone/acetaminophen 7.5/500 mg (generic for Norco, a narcotic pain reliever) on 2/17/14 and 2/26/14 for pain ratings of 8/10 and 10/10, respectively. However, review of a physician's telephone order dated 1/27/14 showed "DC [discontinue] PRN Norco." Interview with the ADON on 3/20/14 at 1:45 PM confirmed the PRN Norco had been discontinued, and was subsequently administered without a valid physician's order.	F 329	F-329 DRUG REGIMIN IS FREE FROM UNNECESSARY DRUGS **Corrective Action** Resident #52's Norco was removed from the medication cart and a medication variance report was completed. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents medication administration records for past 2 weeks to confirm residents receiving narcotics are receiving them in accordance with the physician's orders and orders are correct on medication administration records. Corrective actions will be taken as needed.	
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 329	Continued From page 15 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a valid physician's order for medication was obtained prior to medication administration for 1 of 21 sample residents (#52). The findings were: Review of the medical record revealed resident #52 was admitted to the facility on 5/24/11 with diagnoses that included joint pain and muscle disuse atrophy. Review of the resident's MAR for the month of February 2014 revealed the resident received doses of hydrocodone/acetominophen 7.5/500 mg (generic for Norco, a narcotic pain reliever) on 2/17/14 and 2/26/14 for pain ratings of 8/10 and 10/10, respectively. However, review of a physician's telephone order dated 1/27/14 showed "DC [discontinue] PRN Norco." Interview with the ADON on 3/20/14 at 1:45 PM confirmed the PRN Norco had been discontinued, and was subsequently administered without a valid physician's order.	F 329	**Systemic Changes** The Staff Development Coordinator/Designee will provide education to licensed nurses addressing the following of physician orders as they relate to medication administration. The Director of Nursing/Designee will conduct random weekly audits of the medication administration record for four (4) weeks and then monthly for three (3) months to confirm physician orders for narcotic medication administration is correct on medication administration record and orders are followed. **Monitoring** The Director of Nursing /Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 88=D	Continued From page 16 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitary conditions in the kitchen related to sanitizer solutions and expired food products. The findings were: 1. Observation on 3/18/14 at 4:30 PM showed there were two buckets filled with sanitizer solution in the production area of the kitchen. The solution in both buckets was noted to be murky and have food particles floating on the surface. In addition, both buckets had a build-up of a black substance around the inside edges. At this time, cook #1 observed the testing of the quaternary ammonia sanitizer solutions which showed it was between 0-150 parts per million (PPM) in each bucket. Review of the product label for the "Oasis 146 multi- quat" sanitizer showed a concentration of 200- 400 ppm was needed to sanitize surfaces. Interview with the dietary manager on 3/18/14 at 4:40 PM verified the solution needed to be changed. At 5 PM dietary aide #1 changed the sanitizer solution and tested it for each bucket. The concentration of chemical was at a minimum of 200 ppm; however, the buckets remained	F 371	F-371 FOOD PROCURE / STORE / PREPARE / SERVE / SANITARY **Corrective Action** The sanitation buckets were removed and replaced with new sanitation buckets. Appropriate PPM levels of sanitizer solution are placed in sanitation buckets. The wet wiping cloth was removed from the food preparation counter. All expired food products have been removed from the kitchen. **Identification of Others** The Dietary Manager/Designee will conduct a kitchen-wide audit to confirm that sanitation buckets are clean and in good condition, the appropriate level of PPM sanitizer solution is used in sanitizer buckets, wet wiping cloths are not present on food preparation counters, and expired food products are not present.	

SB 4/15/14

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/20/2014

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See next page KB 4/15/14

Cheyenne Health Care Center

New Day

2700 East 12th Street * Cheyenne, WY * 82001

Phone: (307) 634-7986 FAX: (307) 634-1325

Services Available

- 24-Hour Skilled Nursing Services
- 7 day a week Admissions
- Private & Semi-Private Rooms
- On-site evaluations for Admission
- Free Transportation to Medical Appts.
- IV Therapy, Wound Care, and Pain Management
- Registered Dietician
- Fall Assessment Program
- Dental, Podiatry & Optometry Services
- Discharge Planning Services
- Therapeutic Activity Program

Therapy

- Physical Therapy
- Occupation Therapy
- Speech/Language Pathologists
- Respiratory Therapy

Care Programs

- Rehabilitation Care
- Restorative Care
- Long-term Care
- Respite/Short-term Care
- Hospice Care

Payor Sources Accepted

- Medicare
- Medicaid
- Private Pay
- Managed Care/Insurance Plans

To: RCW Pearson

FAX #: 777-7127

Date: 4-13-14

From: DD Stokes

Number of pages including cover sheet: 81 84

Message:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 18 of 7 days.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure progress notes were written by the physician after visits were made as required for 2 of 21 sample residents (#38, #100). The findings were: 1. Review of the medical record showed resident #38 was admitted to the facility on 12/17/09. Review of the medical record showed the physician made a visit to examine the resident on 1/30/14. However, there was no evidence the physician had written progress notes for that visit. Interview with the DON on 3/20/14 at 4:15 PM revealed the physician was "behind" in his paper work. 2. Review of the medical record showed resident #100 was admitted to the facility on 6/7/13. Review of the medical record showed the physician made visits to examine the resident on 9/5/13, 10/31/13, 12/20/13, 2/11/14, 2/20/14, and	F 386	F-386 PHYSICIAN VISITS – REVIEW CARE/NOTES/ORDERS **Corrective Action** Physician progress notes were obtained from 1/30/14 physician visit for resident #38 and placed in medical record. Resident #100 no longer resides in facility. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents for the past 60 days to confirm that physician visits are current and current physician progress notes are present in the medical record to support a physician visit. Corrective actions will be taken for identified concerns. **Systemic Changes** The Director of Nursing/Designee will conduct an audit 2 times per month for three (3) months for frequency of physician visits	

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F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview,the facility failed to ensure physician visits were made every sixty days as required for 1 of 21 sample residents (#38). The findings were: Review of the medical record showed no evidence the physician made a visit to examine resident #38 from 10/1/13 through 1/30/14 for a total of 121 days. Interview with the DON on 3/20/14 at 4:15 PM verified there was no evidence the physician saw the resident every sixty days as required.	F 387	F-387 FREQUENCY & TIMLINESS OF PHYSICIAN VISITS **Corrective Action** Resident #38 had a physician visit on January 30, 2014 and will have another physician visit prior to April 21, 2014. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents for the past 60 days to confirm that physician visits are current and current physician progress notes are present in the medical record to support a physician visit. Corrective actions will be taken for identified concerns.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 20 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents received the physician ordered medications at the designated times for 2 of 21 sample residents (#41, #97). The findings were: 1. Review of the medical record showed resident #97 had diagnoses which included chronic airway obstruction. Further review showed a physician's order for Combivent 18 mcg-103 mcg/actuation aerosol to treat this condition. The order was written on 12/30/13 and was ordered four times per day. Review of the January 2014 MAR showed the resident was not administered the Combivent at any time during his/her 14 day stay in the facility. Review of the notes on the MAR revealed the Combivent was unavailable for	F 425	F-425 PHARMACEUTICAL SVC – ACCURATE PROCEDURES **Corrective Action** Resident #97 discharged from the facility. Resident #41's methocarbamol and baclofen have been obtained and are being administered in accordance with the physician's order. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current month Medication Administration Records (MAR) and Treatment Administration Records (TAR) compared to medications available to confirm that physician ordered medications are available. Corrective actions will be taken for any identified concerns.	

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	536025	A. BUILDING _____ B. WING _____	C 03/20/2014

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F 425	Continued From page 21 administration. Interview with the DON and ADON on 3/20/14 at 1 PM verified the resident did not receive the ordered medication. The DON and ADON further stated they were unsure as to why the medication was not available. 2. Review of the medical record showed resident #41 had diagnoses to include neurogenic bladder and muscle spasms. Review of the March 2014 recapitulation of orders showed orders for methocarbamol 500 mg three times daily for muscle spasticity. Review of the March 2014 MAR showed the resident did not receive this medication because it was unavailable on 3/15/14 at 8 PM, on 3/16/14 at 4 AM and on 3/16/14 at noon. In addition, review of the February 2014 MAR showed the resident did not receive the noon dose of baclofen 10 mg (for muscle spasticity) on 2/19/14 because it was not in stock. Interview with the DON and ADON on 3/20/14 at 1 PM verified these medications were not administered because they were unavailable. They further said they were unsure as to why the medications were not available.	F 425	**Systemic Changes** The Director of Nursing/Designee will conduct weekly audits for four (4) weeks and monthly for three (3) months to confirm that physician ordered medications are available. The Staff Development Coordinator/Designee will provide education to licensed nurses addressing medication administration in accordance with physician's orders and the protocol on addressing unavailable medications. **Monitoring** The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by:	F 464	F-464 REQUIREMENTS FOR DINING AND ACTIVITY ROOMS	

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F 464	Continued From page 22 Based on observation, resident interview, review of resident council meeting minutes and staff interview, the facility failed to provide an area for resident dining that accommodated residents utilizing walkers and wheelchairs without crowding for 3 of 3 meals observed in the main dining room. The findings were: Observation of the facility's meal services on 3/17/14 at 12:15 PM, 3/18/14 at 5:48 PM, and 3/19/14 at 5:36 PM revealed the main dining area was crowded. The following concerns with crowding in the main dining room were identified: a. Observation on 3/18/14 at 5:48 PM and again on 3/19/14 at 5:52 PM showed facility staff had to squeeze between tables and wheelchairs, or step over wheelchair wheels in order to serve the meals and assist residents. b. Observation of the evening meal on 3/19/14 showed the following concerns: 1. Observation at 5:34 PM showed resident #49 attempted to exit the dining room, stating "I gotta get out! I've got company in my room." The resident was unable to maneuver his/her way out of the dining room without the assistance of RN #2. This RN was able to help the resident out of the dining room after first moving 2 other residents in their wheelchairs, and a third resident's walker out of the way. 2. At 5:36 PM resident #20 was observed attempting to enter the dining room. The entrance to the dining room was blocked at that time by several other residents in wheelchairs, and the resident left without going into the dining room to eat at that time. 3. At 5:36 PM resident #36, who utilized a motorized wheelchair for locomotion, was observed attempting to maneuver into place at one of the dining room tables. When s/he	F 464	Resident interviews will be conducted by NHA or designees to determine any current resident concerns regarding dining room space. Concern forms will be completed for any identified issues. **Systemic Changes** The Dietary Manager/Designee will conduct random weekly audits for four (4) weeks and monthly for three (3) months to confirm that adequate space is available for residents. A Resident Dining Committee will be held monthly to discuss any resident concerns regarding dining, including the environment in the dining room. The Staff Development Coordinator/Designee will provide education to all staff addressing the implementation of an open dining concept. The Dietary Manager/Designee will utilize the assisted dining area if needed to control resident flow into the dining room.	

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F 464	Continued From page 23 became stuck facing the wall in between tables, another resident got up from his/her place and moved the table so resident #36 could turn the motorized wheelchair to face the table. During an interview on 3/20/14 at 3:30 PM, resident #36 stated the dining room was very crowded which made it difficult for residents with wheelchairs to maneuver. This resident further said administration had been notified of the residents' concerns regarding the crowded dining room but nothing had changed in the dining room regarding crowding. 4. Observation at 5:50 PM showed resident #54 attempted to exit the dining room. The resident was wearing padded boots on his/her lower legs which were extended in front of the wheelchair on the leg rests. The resident was unable to maneuver his/her way out of the dining room, repeatedly bumped his/her legs on furniture and other residents' wheelchairs. Resident #54 finally asked other residents to move so that s/he could get out of the dining room. Interview with resident #54 on 3/20/14 at 1:30 PM revealed the dining room was very crowded at mealtimes, and it was a common occurrence for him/her to be bumped into. This resident further stated the crowded dining room had been a problem for about 4 to 6 months. 5. At 5:55 PM, resident #2 was observed to be entangled with another resident's walker as s/he attempted to leave the dining room. Interview with the resident at that time revealed the dining room was "always like this." c. Review of the 12/26/13 resident council meeting minutes revealed all 14 residents who attended complained the dining experience could get "crowded at times." d. Review of the 1/29/14 resident council meeting minutes revealed dietary staff told the 26	F 464	**Corrective Action** In order to create more space in the dining room, tables have been removed and the dining room has been reconfigured. To address an appropriate flow of residents in and out of the dining room, residents are being served upon arrival to the dining room, leaving the dining room upon completion of their meal, and tables/spaces are cleaned in preparation for additional residents. An open dining concept has been implemented. **Identification of Others** The Dietary Manager/Designee will evaluate the available space in the dining room during meals to confirm adequate space is available to comfortably provide dining services to residents.	

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F 464	Continued From page 24 residents in attendance some changes had been made in the dining room and they "need time to adjust to the change." e. Review of the resident council meeting minutes dated 2/26/14 revealed the 27 residents who attended the meeting verbalized "seating is still a problem getting in and out of dining room." f. Interview with the facility administrator on 3/20/14 at 6:10 PM revealed facility administration was aware of the crowding in the main dining room and acknowledged the problem of crowding in the dining room had not yet been resolved.	F 464	**Monitoring** The Dietary Manager/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ventilation system was working in 1 of 6 hallways (the South East Hallway). The findings were: Periodically on 3/17/14, 3/18/14, 3/19/14 and 3/20/14 strong unpleasant odors were noted near the front lobby and the South East hallway in the facility. Interview with a family member on 3/18/14 at 3:05 PM revealed she noticed odors in the facility, stating "it [facility] doesn't smell clean most of the time." On 3/20/14 at 9:25 AM interview and observation with the maintenance director revealed the air vents that extracted air from the resident bathrooms on the South East hall were not functional. The director stated the	F 467		

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F 464	Continued From page 24 residents in attendance some changes had been made in the dining room and they "need time to adjust to the change." e. Review of the resident council meeting minutes dated 2/26/14 revealed the 27 residents who attended the meeting verbalized "seating is still a problem getting in and out of dining room." f. Interview with the facility administrator on 3/20/14 at 6:10 PM revealed facility administration was aware of the crowding in the main dining room and acknowledged the problem of crowding in the dining room had not yet been resolved.	F 464		
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ventilation system was working in 1 of 6 hallways (the South East Hallway). The findings were: Periodically on 3/17/14, 3/18/14, 3/19/14 and 3/20/14 strong unpleasant odors were noted near the front lobby and the South East hallway in the facility. Interview with a family member on 3/18/14 at 3:05 PM revealed she noticed odors in the facility, stating "it [facility] doesn't smell clean most of the time." On 3/20/14 at 9:25 AM interview and observation with the maintenance director revealed the air vents that extracted air from the resident bathrooms on the South East hall were not functional. The director stated the	F 467	F-467 ADEQUATE OUTSIDE VENTILATION – WINDOW/MECHANIC **Corrective Action** The air vents used to extract air from resident's bathrooms on the South East hallway was repaired. **Identification of Others** The Maintenance Director/Designee will conduct a facility-wide audit to confirm the air vents used to extract air from resident bathrooms are properly working.	

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F 464	Continued From page 24 residents in attendance some changes had been made in the dining room and they "need time to adjust to the change." e. Review of the resident council meeting minutes dated 2/26/14 revealed the 27 residents who attended the meeting verbalized "seating is still a problem getting in and out of dining room." f. Interview with the facility administrator on 3/20/14 at 6:10 PM revealed facility administration was aware of the crowding in the main dining room and acknowledged the problem of crowding in the dining room had not yet been resolved.	F 464		
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ventilation system was working in 1 of 6 hallways (the South East Hallway). The findings were: Periodically on 3/17/14, 3/18/14, 3/19/14 and 3/20/14 strong unpleasant odors were noted near the front lobby and the South East hallway in the facility. Interview with a family member on 3/18/14 at 3:05 PM revealed she noticed odors in the facility, stating "it [facility] doesn't smell clean most of the time." On 3/20/14 at 9:25 AM interview and observation with the maintenance director revealed the air vents that extracted air from the resident bathrooms on the South East hall were not functional. The director stated the	F 467	**Systemic Changes** The Maintenance Director/Designee will conduct weekly audits for four (4) weeks and monthly for three (3) months to confirm the air vents for extracting air from resident bathrooms are working properly. The Maintenance Director/Designee will incorporate into the monthly maintenance program the inspection of the air vents used to extract air from resident's bathrooms to confirm they are properly working. **Monitoring** The Maintenance Director/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	

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F 467	Continued From page 25 belt on the roof top unit for this hallway must have snapped. At 10:15 AM that day, the maintenance director confirmed the belt was broken.	F 467		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed in accordance with physician's orders for 1 of 21 sample residents (#41). The findings were: Review of the March 2014 recapitulation of physician orders showed an order for a basic metabolic panel (BMP) laboratory test monthly for resident #41. The order was originally written on 6/29/10. Review of the entire medical record showed no evidence the BMP was performed during the month of January 2014. Interview with the DON on 3/20/14 at 4:15 PM verified the BMP scheduled for January 2014 was not performed as ordered.	F 502	F-502 ADMINISTRATION **Corrective Action** Resident #41's basic metabolic panel was obtained on February 12, 2014 and March 28, 2014. **Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents for the past 90 days to confirm laboratory tests are conducted in accordance with physician orders. Corrective actions will be taken for identified concerns. **Systemic Changes** The Director of Nursing/Designee will conduct random weekly audits of resident medical records for four (4) weeks and monthly for three (3) months to confirm laboratory tests are conducted in accordance with physician orders.	
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by:	F 511		

BB 4/15/14

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F 467	Continued From page 25 belt on the roof top unit for this hallway must have snapped. At 10:15 AM that day, the maintenance director confirmed the belt was broken.	F 467		
F 502 SS=D	483.75(l)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed in accordance with physician's orders for 1 of 21 sample residents (#41). The findings were: Review of the March 2014 recapitulation of physician orders showed an order for a basic metabolic panel (BMP) laboratory test monthly for resident #41. The order was originally written on 6/29/10. Review of the entire medical record showed no evidence the BMP was performed during the month of January 2014. Interview with the DON on 3/20/14 at 4:15 PM verified the BMP scheduled for January 2014 was not performed as ordered.	F 502	The Staff Development Coordinator/Designee will provide education to licensed nurses addressing conducting laboratory tests in accordance with the physician's order and the utilization of a laboratory tracking tool to validate laboratory tests were conducted. Monitoring The Director of Nursing/Designee will bring the results of the audits to the monthly QA&A Committee for 3 months for review and recommendations. Date of compliance is April 21, 2014.	
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by:	F 511		

RB 4/15/14

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F 467	Continued From page 25 belt on the roof top unit for this hallway must have snapped. At 10:15 AM that day, the maintenance director confirmed the belt was broken.	F 467		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed in accordance with physician's orders for 1 of 21 sample residents (#41). The findings were: Review of the March 2014 recapitulation of physician orders showed an order for a basic metabolic panel (BMP) laboratory test monthly for resident #41. The order was originally written on 6/29/10. Review of the entire medical record showed no evidence the BMP was performed during the month of January 2014. Interview with the DON on 3/20/14 at 4:15 PM verified the BMP scheduled for January 2014 was not performed as ordered.	F 502		
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by:	F 511	F-511 RADIOLOGY FINDINGS – PROMPTLY NOTIFY PHYSICIAN **Corrective Action** Resident #49's x-ray results were obtained and faxed to the physician on 3-20-14.	

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F 511	Continued From page 26 Based on medical record review and staff interview, the facility failed to promptly notify the physician of x-ray findings for 1 of 1 sample resident (#49) with recent x-rays. The findings were: Review of the medical record for resident #49 revealed a physician's order dated 2/12/14 to "Recheck CXR [chest x-ray] in 2 weeks." No chest x-ray results for the end of February 2014 could be located in the medical record. Interview with the ADON on 3/20/14 at 3:50 PM revealed the x-ray was performed on 2/27/14, however, the results of the x-ray were not obtained and faxed to the physician until the surveyor asked for the results on 3/20/14.	F 511	**Identification of Others** The Director of Nursing/Designee will conduct a facility-wide audit of current residents for the past 90 days to confirm a resident's physician has been promptly notified of radiology results. Corrective actions will be taken for identified concerns. **Systemic Changes** The Director of Nursing/Designee will conduct random weekly audits of resident medical records for four (4) weeks and monthly for three (3) months to confirm that physicians have been promptly notified of radiology results and results are placed in medical record.	
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to file x-ray results in the resident's medical record for 1 of 1 sample resident (#49) who had x-rays ordered. The findings were: Review of the medical record for resident #49 revealed a physician's telephone order dated 2/12/14 to "Recheck CXR [chest x-ray] in 2 weeks." However, no chest x-ray results for the end of February 2014 could be located in the medical record. Interview with the ADON on	F 513		

RB 4/15/14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to file x-ray results in the resident's medical record for 1 of 1 sample resident (#49) who had x-rays ordered. The findings were: Review of the medical record for resident #49 revealed a physician's telephone order dated 2/12/14 to "Recheck CXR [chest x-ray] in 2 weeks." However, no chest x-ray results for the end of February 2014 could be located in the medical record. Interview with the ADON on	F 513	Date of compliance is April 21, 2014.	

4/13/14

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CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 513	Continued From page 27 3/20/14 at 3:50 PM revealed the x-ray had been performed on 2/27/14. However, the results of the x-ray were not filed in the medical record until the surveyor asked for the results on 3/20/14.	F 513	F-513 X-RAY / DIAGNOSTIC REPORT IN RECORD-SIGNED/DATED **Corrective Action** Resident #49's x-ray results were filed in the medical record on 3-20-14. **Identification of Others** The Director of Nursing or designee will conduct a facility-wide audit of current residents for the past 90 days to confirm diagnostic test results are placed in the resident's medical record. **Systemic Changes** The Director of Nursing/Designee will conduct random weekly audits of resident medical records for four (4) weeks and monthly for three (3) months to confirm that physicians have been promptly notified of radiology results and results are placed in medical record.	

LB 4/15/14

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4/15/14